Division of Public and Behavioral Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2939AGC	A. BUILDING: _____ B. WING _____	11/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK BUFFALO ASSISTED LIVING FACILI	3890 N BUFFALO DR LAS VEGAS, NV 89129

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments This Statement of Deficiencies was generated as a result of an annual State Licensure survey and complaint investigation conducted on your facility on 11/5/15 to 11/12/15. This State Licensure survey was conducted by the authority of NRS 449.0307 Powers of the Division of Public and Behavioral Health. The facility is licensed for one hundred and thirteen total residential facility beds which provide assisted living services for eighty five facility beds for elderly or disabled persons and/or persons with chronic illnesses Category I residents with twenty eight facility beds Alzheimer's disease and/or chronic illnesses Category II residents. The facility received a grade of D. The complaint investigative process was initiated by the Division of Public and Behavioral Health on 11/5/15. Complaint #NV00044257 -The complaint contained one allegation. The complaint could not be substantiated. The allegation the building was covered in black mold which was going through the ventilation system could not be substantiated. The investigation into the allegation included: - Interviews conducted with the administrator, acting maintenance director, and chief executive officer. - Record review of maintenance logs.	Y 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

12/04/15

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Y 000	Continued From page 1 - Facility walk through and observation. Immediate Jeopardy was identified on 11/5/15 at 3:43 PM for TAG Y 0170 - NAC 449.209 Health and sanitation. The facility provided an acceptable plan for correction of the Immediate Jeopardy at 4:45 PM on 11/5/15. The findings and conclusions of any investigation by the Division of Public and Behavioral Health shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following deficiencies were identified:	Y 000		
Y 070 SS=D	449.196(1)(f) Qualifications of Caregiver-8 hours training NAC 449.196 Qualifications of caregivers. 1. A caregiver of a residential facility must: (f) Receive annually not less than 8 hours of training related to providing for the needs of the residents of a residential facility. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 2 employees received 8 hours of annual caregiver training (Employee #1). Findings include: On 11/5/15, a review of employee files revealed Employee #1 was hired on 8/1/11. The file lacked documented evidence of completion of caregiver training for 2014.	Y 070		

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Y 070	Continued From page 2 On 11/5/15 at 2:41 PM, Employee#17 acknowledged the missing training. Severity: 2 Scope: 1	Y 070		
Y 074 SS=D	NRS 449.093 Elder Abuse Training NRS 449.093 Training to recognize and prevent abuse of older persons: Persons required to receive; frequency; topics; costs; actions for failure to complete 4. An administrator or other person in charge of a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the facility, agency or home provides care to a person and annually thereafter. 5. An employee who will provide care to a person in a facility for intermediate care, facility for skilled nursing, agency to provide personal care services in the home, facility for the care of adults during the day, residential facility for groups or home for individual residential care must receive training to recognize and prevent the abuse of older persons before the employee provides care to a person in the facility, agency or home and annually thereafter. This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to ensure 2 of 15 employees received training to recognize and prevent the abuse of older persons (Employees #1 and #9).	Y 074		

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Y 074	Continued From page 3 Findings include: On 11/5/15, a review of employee files revealed the following: - Employee #1 was hired on 8/1/11. The file lacked documented evidence of elder abuse training for 2014. - Employee #9 was hired on 6/23/14. The file lacked documented evidence of elder abuse training for 2015. On 11/5/15 at 2:41 PM, Employee #17 acknowledged the missing training. Severity: 2 Scope: 1	Y 074		
Y 170 SS=I	449.209(1)(a) Health and Sanitation-Safe water and sewage NAC 449.209 Health and sanitation. 1. A residential facility must: (a) Have a safe and sufficient supply of water, adequate drainage and an adequate system for the disposal of sewage. This Regulation is not met as evidenced by: Based on interview and observation, the facility failed to maintain a safe water temperature. Findings include:	Y 170		

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Y 170	Continued From page 4 On 11/5/15 the following water temperatures were recorded using a temperature gauge in the following rooms: - At 10:34 AM, the water from the bathroom faucet of room #207 was 163.3 degrees Fahrenheit. - At 10:40 AM, the water from the bathroom faucet of room #210 was 150.1 degrees Fahrenheit. The Resident in the room reported the water has sometimes been too hot. - At 11:11 AM, the water from the bathroom faucet of room #217 was 147.1 degrees Fahrenheit. - At 11:25 AM, the water from the bathroom faucet of room #239 was 160.4 degrees Fahrenheit. - At 11:15 AM, the water from the bathroom faucet of room #176 was 138 degrees Fahrenheit. - At 11:15 AM, the water from the bathroom faucet of room #207 was 163.3 degrees Fahrenheit. - At 11:20 AM, the water from the bathroom faucet of room #171 was 123 degrees Fahrenheit. - At 11:22 AM, the water from the bathroom facet of room #170 was 134 degrees Fahrenheit. - At 11:34 AM, the water from the bathroom faucet of room #179 was 142 degrees Fahrenheit. The resident in the room reported the water is too hot and has to add cold water to utilize the hot water. - At 11:40 AM, the water from the bathroom faucet of room #102 was 145 degrees Fahrenheit. - At 11:41 AM, the water from the kitchenette sink of room #101 was 141 degrees Fahrenheit. The resident in the room indicated the water was too	Y 170		

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Y 170	Continued From page 5	Y 170		

hot. The resident reported they told maintenance staff about the issue in the previous two months, however they did not notice a decrease in water temperature since reporting the concern.
- At 11:46 AM, the water from the bathroom faucet of room #2 in the memory care unity was 149.9 degrees Fahrenheit.
- At 11:49 AM, the water from the bathroom faucet of room #3 in the memory care unit was 150 degrees Fahrenheit.
- At 11:51 AM, the water from the bathroom faucet of room #11 in the memory care unit was 132 degrees Fahrenheit.
- At 11:55 AM, the water from the bathroom faucet of room #10 in the memory care unit was 135 degrees Fahrenheit.
- At 11:57 AM, the water from the bathroom facet of room #13 in the memory care unit was 137.9 degrees Fahrenheit.
- At 12:05 PM, the water from the bathroom faucet of room #7 in the memory care unit was 146 degrees Fahrenheit.
- At 12:10 PM, the water from the bathroom faucet of room #6 in the memory care unit was 129 degrees Fahrenheit.

On 11/5/15 at 12:41 PM the facility staff reported a plumber arrived to diagnosis the issues with the hot water.

On 11/5/15 at 12:45 PM, interviews with residents in the dining room revealed the following:

- The residents from rooms #218, 248, 265, 266, and 163 reported the water was too hot to use without having to adding cold water to lower the temperature.
- A resident from room #263 indicated the hot water is too hot. The resident reports the hot water has been an issue for the previous nine

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Y 170	Continued From page 6	Y 170		

months.
- The resident from room #154 report they noticed the water was too hot in their room approximately two months ago. The resident reported the temperature appeared to have decreased since then, however they still needed to add cold water when utilizing the hot water.
- A resident in room #111 reported it was too hot to use the hot water without using the cold water valve. The resident indicated the hot water has been an issue for the previous nine months.

On 11/5/15 at 1:00 PM, an employee who wanted to remain anonymous revealed they felt the water was too hot for the past several months and did not report it to facility staff. The employee explained they knew other caregivers reported the problem with the hot water to the medication technician staff who instructed the caregivers to utilize the cold water in conjunction with the hot water to avoid burning the residents.

On 11/5/15 at 1:30 PM, during an interview with another employee who wanted to remain anonymous , the employee indicated they knew the water was too hot, however did not report it as they regulated the temperature themselves with cold water.

On 11/5/15 at 1:56 PM, the acting maintenance director acknowledged the temperatures in the resident rooms on the first floor and in the memory care unit. The acting maintenance director indicated they were not aware of any issues with the hot water temperature and there were no previous maintenance requests to adjust water temperature because of high temperatures.

On 11/5/15 at 2:45 PM, the marketing director acknowledged the temperatures in the resident's

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Y 170	Continued From page 7 rooms on the second floor and indicated they had no previous knowledge of the water temperature being too high. On 11/5/15 at 2:20 PM, the administrator reported the plumber had identified the problem as a faulty temperature control valve. The replacement part needed to be ordered from the east coast and would not arrive until the morning of 11/9/15. On 11/5/15 at 3:43 PM, an Immediate Jeopardy situation was identified. Severity: 3 Scope: 3	Y 170		
Y 178 SS=F	449.209(5) Health and Sanitation-Maintain Int/Ext NAC 449.209 Health and sanitation. 5. The administrator of a residential facility shall ensure that the premises are clean and that the interior, exterior and landscaping of the facility are well maintained. This Regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure the interior and exterior premises were clean and maintained. Findings include: On 11/5/15 9:30 AM, review of maintenance work orders documented on 5/25/15 the toilet overflowed in Room #267. The work order documented to check Room #171 and #266 for water leaks. On 11/5/15 at 9:55 AM, the following were	Y 178		

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Y 178	Continued From page 8 observed during a tour of the facility: - In the laundry room of the Alzheimer's unit the baseboard on the right side of the room was separated from the wall and some of the drywall above the baseboard had peeled. To the right of the toilet, drywall was missing around the pipe and some of the drywall had peeled near the baseboard. - In the living room of the Alzheimer's unit there were three large brown colored stains on the ceiling. One was surrounding the fan above the couch, one was near the back door and another was near the kitchen. - In the Fitness Room, there were two long cracks in the ceiling in the middle of the room and the ceiling was bubbled. - On the first floor, there was dust build-up on two air vents on the ceiling, outside the elevator. - Around the outside of the building there were weeds in the rocks along both sides and in the courtyard in the back of the building. There were overgrown bushes on the pathway of the sidewalks around the building and in the courtyard. There was an overgrown palm tree pressed against one window in the front of the building. - There were approximately ten screens missing on windows observed from the outside of the building. - In Room #3 the bathroom ceiling, above the grab bar, was curved/bubbled with drywall missing in one spot and there was a crack where the ceiling meets the wall.	Y 178		

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Y 178	Continued From page 9 - In Room #5 there was a large crack on the ceiling, the length of the wall, near the bathroom where the ceiling meets the wall and a crack in the bathroom, above the grab bar, where the ceiling meets the wall. - In Room #6 there was a red substance on the ceiling above the bed. - In Room #12 there was a crack in the wall above the air conditioner, there was a black colored substance on the ceiling above the toilet, and the ceiling was bubbled. - In Room #103 there was a brown stain on the ceiling above the toilet. - In Room #108 there were two cracks in the living room ceiling the width of the room. One crack had partially been repaired. - In Room #176 there was a brown stain on the ceiling above the window. - In Room #171 there was a large stain on the ceiling by the front door, there was damaged drywall, the width of the entry way, on the ceiling where the entry way meets the bedroom. There was a crack in the wall, where the ceiling meets the wall, from the front door to just beyond the damaged drywall. - In Room #212 inside the bathroom cabinet the bottom was warped and the molding along the floor, outside the cabinet, was warped and pulled away from the cabinet. - In Room #250 there was a urine odor in Room #250.	Y 178		

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Y 178	Continued From page 10 - In Room #260 there was a black colored substance in the bathroom, under the tile, along the left side of the floor where the bathroom vanity was located. There was a musty/moldy odor in the room. - In Room #266 the bathroom tiles were cracked. On 11/5/15 at 9:55 AM, Maintenance personnel and the Marketing Director acknowledged the findings. On 11/5/15 at 2:22 PM, the Marketing Director reported Room #260 was in the process of being remodeled. The Marketing Director believed here was a leak under the sink and they looked for mold. The Marketing Director reported they put primer down to cover the area. On 11/5/15 in the afternoon, a review of the Resident Council minutes from 10/13/15 revealed residents reported the back lawn needed to be cut and there needed to be landscaping on a regular basis. Severity: 2 Scope: 3	Y 178		
Y 223 SS=F	449.213(3) Laundry-Linen - Equipment, Venting NAC 449.213 Laundry and linen services. 3. The laundry room in a residential facility must be situated in an area which is separate from an area where food is stored, prepared or served. The laundry must be adequate in size for the needs of the facility and maintained in a sanitary manner. The laundry room must contain at least	Y 223		

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Y 223	Continued From page 11 one washer and at least one dryer. All the equipment must be kept in good repair. All dryers must be ventilated to outside the building. If a washer or dryer is located outside the residential facility, the washer or dryer must be in a room or enclosure. This Regulation is not met as evidenced by: Based on observation and interview the facility failed to keep equipment in good repair and the dryer was vented to the outside. Findings include: On 11/5/15 at 9:55 AM, during a tour of the facility observed the washer in the laundry room of the Alzheimer's unit was out of order. On 11/5/15 at 1:56 PM, observed during a tour of the facility two of three washers were out of order in the first floor laundry room and one of three dryer vents were detached. There was lint build-up on the floor and baseboard behind the dryers. On 11/5/15 at 9:55 AM, the acting Maintenance Director reported the Alzheimer's washer had been out of order for six to seven weeks. On 11/5/15 at 1:56 PM, the acting Maintenance Director was unaware of the detached dryer vent. On 11/5/15 at 2:00 PM, a resident, who lives on the first floor, reported 2 of 3 washers in the first floor laundry room have been out of order for months. The resident explained the Alzheimer's unit's washer has been out of order so they have	Y 223		

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Y 223	Continued From page 12 been using the first floor laundry room and it is hard to find a time to wash your clothes because the washer is always in use. The resident reported staff had mentioned it would not more than likely be fixed until the first of the new year. On 11/5/15 in the afternoon, a review of the Resident Council minutes from 10/13/15 revealed residents asked when the new washing machines would be in. Severity: 2 Scope: 3	Y 223		
Y 255 SS=E	449.217(6)(a)(b) Permits - Comply with NAC 446 on Food Service NAC 449.217 Kitchens; storage of food; adequate supplies of food; permits; inspections. 6. A residential facility with more than 10 residents must: (a) Comply with the standards prescribed in chapter 446 of NAC. (b) Obtain the necessary permits from the Health Division. This Regulation is not met as evidenced by: Based on observation on 11/05/15, the facility failed to ensure the kitchen complied with the standards of NAC 446. Findings include: 1. Critical Violations:	Y 255		

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Y 255	Continued From page 13 a. There were five badly dented cans (3 corn, 1 peaches, and 1 Mandarin oranges) in dry storage. 2. Major Violations: a. A Styrofoam bowl, being used as a scoop, was in the bulk flour bin. b. Pink and black grime was observed on the shield in the ice machine. 3. Equipment and Maintenance Violations: a. The ceiling vents in the dry storage room and in the kitchen were heavily soiled with dust. Severity: 2 Scope: 2	Y 255		
Y 431	449.229(2) State Fire Marshall referral NAC 449.229 Requirements and precautions regarding safety from fire. 2. The Bureau shall notify the State Fire Marshal or the appropriate local government, as applicable, if, during an inspection of a residential facility, the Bureau knows of or suspects the presence of a violation of a regulation of the State Fire Marshal or a local ordinance relating to safety from fire. This Regulation is not met as evidenced by: Based on record review, the facility failed to ensure smoke detector checks and fire drills were conducted monthly. - State Fire Marshall Referral. Findings include:	Y 431		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 431	Continued From page 14 On 11/5/15 in the morning, a review of the smoke detector test log revealed a lack of documentation smoke detectors were tested for the months of December 2014 and April, May, July, August, and October 2015. On 11/5/15 in the morning, a review of the fire drill logs revealed a lack of documentation fire drills were performed in December 2014 and March-October 2015. On 11/5/15 in the afternoon, a review of the Resident Council minutes from 8/11/15 and 10/13/15 revealed residents questioned if staff were trained in case of a fire. The minutes document staff's response was yes and ongoing training monthly.	Y 431		
Y 693 SS=F	449.2712(2) Oxygen-Caregiver monitor resident ability NAC 449.2712 Residents requiring the use of oxygen. 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician. (b) Ensure That: (1) The resident's physician evaluates periodically the condition of the resident which necessitates his use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored;	Y 693		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS2939AGC	A. BUILDING: _____ B. WING _____	11/10/2015

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Y 693	Continued From page 15 (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks. (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident. This Regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure oxygen tanks were secured in a rack or to the wall in 1 of 2 medication rooms. Findings include: On 11/5/15 at 10:05 AM, three unsecured oxygen tanks were observed standing upright against the back wall of the second floor medication room. On 11/5/15 at 10:15 AM, the Health Care Coordinator acknowledged the unsecured oxygen tanks. This is a repeat deficiency from the 12/4/14 and 10/1/13 annual State Licensure surveys. Severity: 2 Scope: 3	Y 693		
Y 920 SS=D	449.2748(1-2) Medication Storage	Y 920		

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Y 920	Continued From page 16 NAC 449.2748 Medication: Storage; duties upon discharge, transfer and return of resident. 1. Medication, including, without limitation, any over-the-counter medication, stored at a residential facility must be stored in a locked area that is cool and dry. The caregivers employed by the facility shall ensure that any medication or medical or diagnostic equipment that may be misused or appropriated by a resident or any other unauthorized person is protected. Medication for external use only must be kept in a locked area separate from other medications. A resident who is capable of administering medication to himself without supervision may keep his medication in his room if the medication is kept in a locked container for which the facility has been provided a key. 2. Medication stored in a refrigerator, including, without limitation, any over-the-counter medication must be kept in a locked box unless the refrigerator is locked or is located in a locked room. This Regulation is not met as evidenced by: Based on observation and interview, the facility failed to ensure medications were secure in 2 of 18 rooms inspected (Rooms #255 and 239). Findings include: On 11/5/15 during a facility tour, the following were observed to be unsecured: - Room 239: a resident who self administers their medications resides in the room with a resident for whom the facility administers medications.	Y 920		

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Y 920	Continued From page 17 More than two dozen bottles of unsecured prescription and over the counter medications were observed in the bathroom on an open shelving unit, an unlocked cabinet above the toilet, an unlocked cabinet on the adjacent bathroom wall, and on top of the bathroom sink counter. - Room 255: Super Formula 0.1% nitroglycerin, apply intra-anally, expired 5/25/15, and four bottles of lubricating eye drops were observed in the medicine cabinet in the bathroom. On 11/5/15 at 2:16 PM, the Director of Marketing acknowledged the medications were found unsecured. Severity: 2 Scope: 1	Y 920		
Y1021 SS=D	449.2766(2)(3) Chronic Illness Training NAC 449.2766 Residential facility which offers or provides care for persons with chronic illnesses and debilitating diseases: Application for endorsement; training for employees. 2. Within 60 days after being employed by a residential facility for persons with chronic illnesses, an employee of the facility shall obtain at least 4 hours of in-service training relating to the care provided to such persons and in the actions necessary to control infections. 3. Evidence of training received pursuant to subsection 2 must be included in the employee ' s personnel file.	Y1021		

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Y1021	Continued From page 18 This Regulation is not met as evidenced by: Based on record review and interview, the facility failed to ensure 1 of 15 employees acquired the required four hours of chronic illness training within 60 days of hire (Employee #13). Findings include: Employee #13 was hired on 7/20/15. The file contained documented evidence the employee completed one hour of chronic illness training on 9/21/15. The file lacked documented evidence of an additional three hours of chronic illness training. On 11/5/15 at 2:41 PM, Employee #17 acknowledged the missing documentation of training. Severity: 2 Scope: 1	Y1021		